

Complete form and send to EOHS within 24 hours
Cushwa Hall, Room 2046

Youngtown State University
Supervisor Accident Investigation Report

Name _____ Date of Incident _____ Time _____ am/pm

Employee Non-Employee Department _____ Job Title _____

What was the individual doing at the time of the injury? _____

Body parts affected/injured _____ Unsafe condition? _____

Witnesses? Yes No Name, address, phone # _____

In your opinion, did any of the following contribute to the accident/incident?

- Lack of knowledge/experience (insufficient instruction/training)
- Improper attitude (disregard for instructions/rules)
- Human limitation (fatigue, illness, physical limitations)
- Unsafe condition (defective equipment, poor housekeeping, improper working conditions)

Action taken or will be taken to prevent reoccurrence. Mark all that apply.

- | | |
|--|--|
| <input type="checkbox"/> Reinstruction of person(s) involved | <input type="checkbox"/> Tool/equipment repair/replace |
| <input type="checkbox"/> Reprimand of person(s) involved | <input type="checkbox"/> Improve storage |
| <input type="checkbox"/> Discipline of person(s) involved | <input type="checkbox"/> Eliminate congestion |
| <input type="checkbox"/> Preventive instruction of others | <input type="checkbox"/> Better design/construction |
| <input type="checkbox"/> Job reassignment of employee | <input type="checkbox"/> Use of safer materials/supplies |
| <input type="checkbox"/> Improved inspection procedure | <input type="checkbox"/> Improved illumination/ventilation |
| <input type="checkbox"/> Improved cleanup procedures | <input type="checkbox"/> Reduction of noise/vibration |
| <input type="checkbox"/> Safety guard/device installed | <input type="checkbox"/> Correction other than above |
| <input type="checkbox"/> Protective equipment required | <input type="checkbox"/> Other |

Describe corrective action _____

Name of person responsible for corrective action _____ Date taken _____

_____ Supervisor	_____ Date	_____ Department Head	_____ Date	_____ EOHS	_____ Date
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